



June 21, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1752-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Proposed Changes to Medicaid Provider Enrollment; and Proposed Changes to the Medicare Shared Savings Program

Dear Administrator Brooks-LaSure:

On behalf of the American Speech-Language-Hearing Association (ASHA), I write to offer comments on the fiscal year 2022 acute care and long-term care hospital (LTCH) prospective payment system (PPS) proposed rule. ASHA members, particularly speech-language pathologists (SLPs), provide critical health care services to patients in LTCHs. ASHA's comments focus on the request for information (RFI) on closing the health equity gap.

ASHA is the national professional, scientific, and credentialing association for 218,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students.

Closing the Health Equity Gap in Post-Acute Care Quality Reporting Programs—RFI

ASHA commends CMS for seeking to ensure that Medicare providers address health equity to improve the quality and outcomes of care for their patients. ASHA members are committed to improving health equity. Many of the post-acute care assessment tools, such as the LTCH continuity assessment and record evaluation, capture data that providers and CMS may use to reduce health disparities in the areas of race, ethnicity, transportation, gender, and language access (e.g., interpreter, translated materials). While existing post-acute care assessment tools are beneficial, ASHA recommends that CMS collect additional forms of standardized patient assessment data (SPADEs), and use SPADEs to improve health outcomes. Providers must do more than report this data. Collection and use of health equity data by payers and health care providers may improve population health. For example, the data may be stratified by medically underrepresented groups to determine patient experience. If disparities are identified, then providers may implement strategies focused on improved outcomes of care, as well as develop quality measures to address identified inequities.

ASHA recommends that providers collect standardized data associated with the following:

- **Ability to communicate:** An inability to communicate because of hearing loss, a cognitive or speech impairment, articulation, and/or inability to comprehend clinical

instructions impact a patient's overall ability to participate in the care planning process and benefit from skilled interventions. Effective communication represents the core foundation of patient-centered care. Without it, patients will be less satisfied, less enabled, and may demonstrate more symptoms, higher rates of readmission, and greater use of resources.

- **Insurance coverage:** Health insurance coverage has been identified as a key social determinant of health and is one of the largest barriers to health care access.¹ Lack of health insurance contributes to health disparities. For example, patients who are underinsured or uninsured may forgo or delay necessary care, which impacts the quality and outcomes of care they receive.
- **Access to technology (e.g., broadband internet access or tablets):** Patients without access to technology, as well as patients who lack digital literacy, may not be able to receive timely and clinically appropriate care via telehealth. This barrier unnecessarily delays care and adversely impacts outcomes and quality of care.
- **Forms of economic insecurity such as, but not limited to, housing or food insecurity:** Patients with one or more forms of economic insecurity may have to choose between medical care and other financial demands. The stress of such choices adversely impacts the patient's overall physical and mental health. When forced to choose, medical care may be a lower immediate priority despite the significant financial impact that delaying care may have on an individual's overall economic security.
- **Availability of caregiver support.** Lack of caregiver support creates access challenges that may reinforce health disparities.
- **Health literacy.** The patient's ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions and follow instructions for treatment must be assessed. Health literacy is not restricted to only a person's ability to read and write.² Communication disorders cause difficulties with processing and using health information. Other factors that play a role in how well someone understands health information received through hearing, seeing, and reading include:
 - experience with the health care system,
 - cultural and linguistic factors,
 - the format of materials, and
 - how information is communicated.

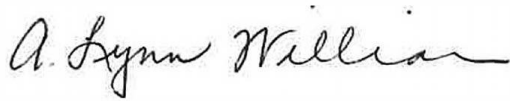
As CMS collects additional health equity SPADEs and develops longitudinal data associated with their impact on quality and outcomes, ASHA recommends sharing this information with providers via designated mechanisms, such as confidential feedback reports, to help further the goal of health equity. However, data sharing is not enough. Although providers in many settings, particularly post-acute care settings, have access to some of this data, it is unclear if the data is used in a meaningful way to improve the quality of care for patients.

ASHA recommends that CMS identify how to hold providers accountable for utilizing the health equity data to improve care for their patients through corrective action plans or other means. For example, as CMS moves from reporting to performance on quality and health equity metrics, it may apply a payment penalty to providers who do not use health equity data to improve care for their patient populations or apply a bonus for those who do so systematically.

ASHA further recommends that CMS identify strategies for mitigating misrepresentation of quality and outcomes data to ensure such data are taken in context with health equity factors. In some cases, providers may misrepresent or misunderstand the data in the absence of the important context health equity metrics provide. For example, a hospital could present superior quality metrics in a particular geographic region as compared to its competitors, but if this hospital had a patient population not adversely impacted by factors such as economic insecurity or language or communication barriers as compared to those same competitors, it would be an inappropriate comparison. ASHA recommends comparing outcomes with respect to similar patient populations or risk adjusted accordingly.

Thank you for your consideration of ASHA's comments. If you or your staff have any questions, please contact Sarah Warren, ASHA's director for health care policy for Medicare, at swarren@asha.org.

Sincerely,



A. Lynn Williams, PhD, CCC-SLP
2021 ASHA President

¹ Healthy People.gov. (n.d.). *Access to Health Services*. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/access-to-health#3>.

² American Speech-Language-Hearing Association. (n.d.) *Health Literacy*. <https://www.asha.org/slp/healthliteracy/>.